Harm Reduction

Responding to the Needs of Our Clients and Our Communities

praxis

MA Department of Public Health
BSAS
Bureau of Substance Addiction Services
Prevent • Treat • Recover • For Life

Center for Social Innovation

The Folks we Serve

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And what we know

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Substance Use

- Currently most people with an opioid use disorder, began using prescription opioids (theirs or someone else's)

- The vast majority of people in recovery from drug or alcohol use will relapse at least once (most multiple times) before being able to fully integrate sobriety into their lifestyle.

- MA has a long history as an entry point for and use of Opioids

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Overdose

- **The biggest context for people overdosing is coming out of treatment and recovery programs**

- Number one cause of accidental death in MA and the U.S.

- Streets are flooded with Fentanyl

- Being an *entry point* for drugs into the U.S., generally means that the drugs on our streets are more dangerous than many other places

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Viral Hepatitis:

- HCV rates are at a staggering level in MA with many treatment/recovery programs reporting rates of infection among their clients to be in the +80%

- Most common blood-born infection in the U.S. and MA

- Although there is a cure for HCV, many clients are unaware of it or don't believe they have access

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HIV/AIDS:

- MA has seen a substantial "uptick" in new HIV infections among drug users in the Northshore
- Although sharing needles is a substantial risk for transmission, it is still believed that sex remains a huge risk for most people, including drug users
- MA is primed for an outbreak similar to Scott County, IN
- Needle Exchange programs best protective factor

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WHAT IS IT?

A philosophy and set of strategies that reduces the negative consequences of harmful behavior

Focuses on the prevention of harm rather than the prevention of behavior.

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WHAT IS IT?

Harm reduction strategies target individuals, environments and policies in an effort to protect the health and safety of individuals and communities

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In The Beginning . . .

- Mid ‘80s to early ’90s
- High number of people dying with HIV/AIDS
- Stigma is rampant in many communities and people with HIV are keeping their status a secret
- High-Risk individuals are identified by how they identify vs. their behaviors (i.e. *“The 4-H Club”*)
- Heroin users (now called IDUs) are strongly blamed (in addition to gay men) for the spread of HIV
- Viewed as a throw-away population (much like gay men), little is done to effectively address the epidemic among IDUs

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Prevention in the Stone Ages

- Prevention work focused on HIV exclusively and sought to ***eliminate*** risk for HIV as opposed to manage it
- Education was believed to be the key, *"If you teach it, they will do it."*
- One- size fits all approach -- context for behavior, motivation for behavior, desire to make change and barriers to making change were not considered important in doing prevention work
- Morality tightly woven in to the fabric of HIV prevention at the time

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CDC "The ABCs of HIV Prevention" 2008

Abstain

Be faithful in marriage, and, when appropriate, use

Condoms 2008

The Frontline Knew Better

- In the U.S., frontline workers saw that the standard “risk reduction” method wasn’t working for everyone. Instinctively, frontline workers took a more client-centered approach.
- In Europe, Peer Educators and frontline outreach workers developed a collection of philosophies and models for service provision, that was sanctioned by far less conservative governments.

They called it **Harm Reduction**

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So What is Harm Reduction?

Harm Reduction Examples

- Individual: Narcan/Naloxone
- Environment: Second hand smoke reduction
- Policy: Good Samaritan Law

Principles of Harm Reduction

- Attempts to engage potential clients where they are at
- Sees clients as the expert on themselves and the leader in the process
- Acknowledge change is not linear

Principles of Harm Reduction

- Define success as any movement towards desired behavior change and acknowledges positive effects of small steps towards behavior change
- Offers a menu of ***practical options***
- Non-judgmental
- Addresses individuals and risks hollistically

Where Does this Fit?

- How do you see these principles playing out in your setting?
- What part of these principles feel like it could be useful or something you're already doing?
- What parts feel counter to your work?

HARM REDUCTION

Both a clinical strategy and a public health strategy aimed at decreasing the damaging effects of risk-taking behaviors.

Harm Reduction in Action: The Case of Scott County, Indiana

Scott County, IN

- Impoverished, rural area of Indiana
- Opioid Epidemic with people injecting Opana (oxy-morphine)
- Most people began their opiate use via legal prescriptions and pill mills
- Many users are nurses injured on the job
- History of state-wide ban on syringe exchange
- People re-using and sharing syringes due to lack of access

Scott County, IN

From 2004 to 2014, Scott County had a total of 8 new HIV diagnosis

Scott County, IN

- January 2015: 8 HIV + cases reported
- February, 2015: 30 cases since December
- March, 2015: 81 cases; CDC declares “epidemic”
- April, 2015: 143 cases: HIV testing clinic opens
- May, 2015: 163 cases
- June, 2015: 180 cases

Scott County, IN

- In April 2015, Gov. called the CDC for help with the outbreak, and was directed to lift the ban on syringe exchange
- As of October 2017 over 220 confirmed cases of HIV, 80% co-infected with HCV
- Experts saying the epidemic has leveled off, but huge burden on systems of care remain
- Significant upticks have been reported in Milwaukee, Beaver County, WI and **Mass**

Scott County, IN: Summary

- Evidence that the syringe exchange is helping to contain the HIV outbreak
- Governor only lifted the ban on syringe exchange for Scott County
- State ban remains in IN and NEPs can only open once a local “outbreak/epidemic is declared”
- Federal Ban on Syringe Exchange has been lifted, marking a fundamental shift in the Federal attitude towards Harm Reduction

Meet Your Praxis Client!

- In groups or in pairs
- Each group will “meet” their client
- Take off your ”provider hat”
- As a group, discuss your first few impressions of the client

The Shame of Drug Use

- What are the message we get about Drug Use?
- What language do we use regarding drug users?
- What are the assumptions people make about drug users?
- How does this impact their recovery?

“When you call me an addict, you take away everything that is lovely about me.”

Impact of Stigma

- In what ways do your programs reinforce the stigma that your clients may experience?

- In what ways do your program's services help to counter or address the stigma clients experience?

Pillars of Harm Reduction

- Person-Centered Care
- Stages of Change
- Recognizing the Impact of Trauma
- Understanding Risk Behaviors & Protective Factors/Strategies

Pillar I:
Person-Centered Care

Person-Centered Care

A way of thinking and doing things that sees the people using health and social services as *equal* partners in planning, developing and monitoring care to make sure it meets their needs.

Four Principles of Person-Centered Care

- Affording people dignity, compassion, and respect
- Offering coordinated care, support, or treatment
- Offering personalized care, support, or treatment
- Supporting people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life

The Health Foundation

How do you build trusting relationships with clients?

- Using a strengths based lens
- Partnering with client to determine goals, pace, and direction
- Engaging in non-judgmental interactions
- Keep showing up (be consistent)

What would be a strengths-based frame for….

Compulsive

Demanding

Dramatic

Manipulative

Nosy

Think of a client that frustrates you…

What are their **strengths?**

Your Praxis Client…

- What are your initial impressions?
- What are their strengths?
- What might be some ways to build rapport?

Pillar II:
Stages of Change

What does it look like in practice to…

"Meeting people where they are at?"

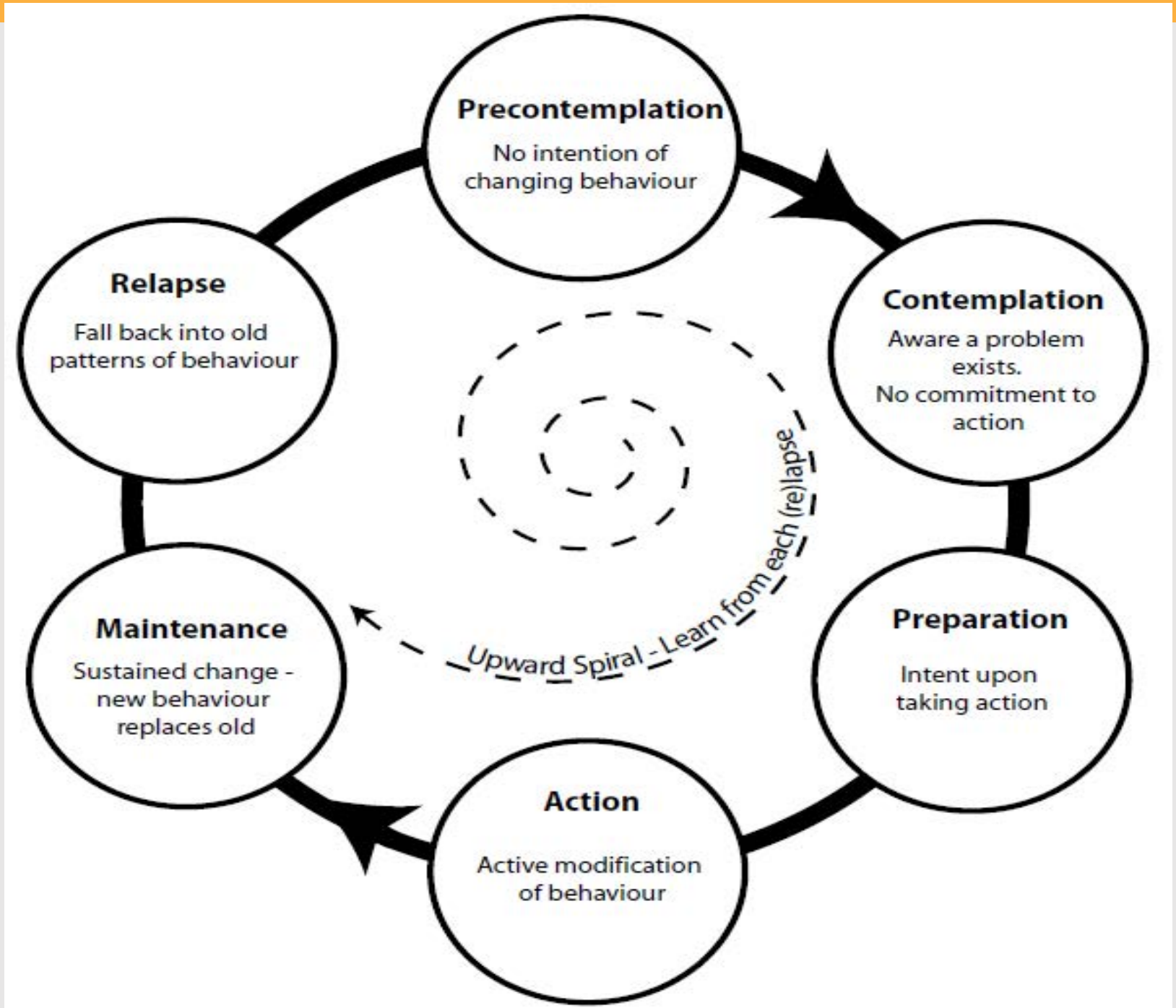
- Understanding where a person is at in reference to their readiness to make changes, including going into recovery.

- Being able to speak to the person from that specific stage of readiness and not impose our agenda or expectations on them.

Stages of Change

- Behavior change model developed by Prochaska and DiClemente in 1983
- Before this model, behavior change had been seen as an “event” such as “quitting smoking” “stopping drinking” etc.
- Stages of Change sees change as a process over time

Stages of Change



Why use Stages of Change with Harm Reduction?

- Tool to help assess ”where a person is at”
- Help guide approach to working with individual “where they are”
- Many providers talk to people as if they are at “Action” stage when they might be at ”Contemplation” etc.
- Model acknowledge relapse as part of the process

Pillar III:
Recognizing Trauma and Its Impact on Those We Serve

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“Trauma is the most avoided, ignored, denied, misunderstood, and untreated cause of human suffering.”

-Peter A Levine in *Healing Trauma*

Overwhelming demands placed upon the physiological system that results in a profound felt sense of vulnerability and/or loss of control

- *Robert D. Macy*

Trauma

Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.

- *Judith Herman*

“Trauma is a thief”

What gets stolen?

Sense of safety; trust; belief in goodness of self, other people and the world; self-regulation, inner calm, feeling of centeredness; ability to problem-solve; ability to respond vs. react; control, autonomy, empowerment; confidence; health/protective factors; self-esteem, connection to own body.

Trauma has an impact on how one sees one's self, sees another, and sees the world

How might survivors you know complete these sentences?

The world is…

They always think I…

I will never be…

Because of me…

I am…

In short, trauma is about loss of connection – to ourselves, to our bodies, to our families, to others, and to the world around us…It is often hard to recognize, because it doesn’t happen all at once. It can happen slowly, over time…”

-Peter Levine

Most behaviors are adaptations and rooted in the history of our experiences.

Trauma-informed care is based on an understanding that recovery is possible and achievable for everyone, regardless of how vulnerable they may appear.

Harm Reduction is Trauma Responsive

- Safety = Establishing a space that is non-judgmental and encourages open, honest dialogue
- Trust/Transparency = Establishing rapport and connection
- Collaboration = Honoring people's experience and the expertise they bring to the table
- Choice & Control = To promote agency and build investment in the process
- Empowerment & Voice = Recognizing their power and developing their voice

Harm Reduction

Partnering with client to take small steps towards any positive change.